

		FOR OHF USE					

LL1

2001  
STATE OF ILLINOIS  
DEPARTMENT OF PUBLIC AID  
FINANCIAL AND STATISTICAL REPORT FOR  
LONG-TERM CARE FACILITIES  
(FISCAL YEAR 2001)

IMPORTANT NOTICE  
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044750

Facility Name: Community Nursing & Rehabilitation Center

Address: 1136 North Mill Street      Naperville      60563  
Number      City      Zip Code

County: DuPage

Telephone Number: (630) 355-3300      Fax # (630) 355-1417

IDPA ID Number: 3643458778001

Date of Initial License for Current Owners: 04/01/2000

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
		<input checked="" type="checkbox"/>	"Sub-S" Corp.		
		<input type="checkbox"/>	Limited Liability Co.		
		<input type="checkbox"/>	Trust		
		<input type="checkbox"/>	Other		

In the event there are further questions about this report, please contact:  
Name: Ms. Christine Hanover      Telephone Number: (312) 634-3400  
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed) _____	(Date) _____
	(Type or Print Name) _____	
	(Title) _____	
Paid Preparer	(Signed) _____	SEE ACCOUNTANTS' COMPILATION REPORT
	(Date) _____	
	(Print Name and Title) _____	
	(Firm Name & Address) _____	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone) _____	(312) 634-3400      Fax # (312) 634-5518
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001      Phone # (217) 782-1630		

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Community Nursing & Rehabilitation Center

#    0044750      Report Period Beginning:      01/01/01      Ending:    12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds      N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>48</u>	Skilled (SNF)	<u>48</u>	<u>17,520</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>105</u>	Intermediate (ICF)	<u>105</u>	<u>38,325</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>153</u>	TOTALS	<u>153</u>	<u>55,845</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>4,657</u>		<u>5,824</u>	<u>10,481</u>	8
9	SNF/PED					9
10	ICF	<u>21,245</u>	<u>6,737</u>		<u>27,982</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>25,902</u>	<u>6,737</u>	<u>5,824</u>	<u>38,463</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.)      68.87%

D. How many bed-hold days during this year were paid by Public Aid?

None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?      Yes

G. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES    ☒      NO    ☐      Non-allowable costs have been  
eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES    ☐      NO    ☒

I. On what date did you start providing long term care at this location?  
Date started      04/01/2000

J. Was the facility purchased or leased after January 1, 1978?  
YES    ☒      Date    04/01/2000      NO    ☐

K. Was the facility certified for Medicare during the reporting year?  
YES    ☒      NO    ☐      If YES, enter number  
of beds certified      48      and days of care provided      4,672

Medicare Intermediary      AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRAUAL    ☒      MODIFIED  
CASH\*    ☐      CASH\*    ☐

Is your fiscal year identical to your tax year?      YES    ☒      NO    ☐

Tax Year:      12/31/2001      Fiscal Year:      12/31/2001  
\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 01/01/01 Ending: 12/31/01

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	286,465	47,144	7,151	340,760		340,760		340,760			1
2	Food Purchase		174,580		174,580		174,580	(2,629)	171,951			2
3	Housekeeping	140,723	24,708		165,431		165,431		165,431			3
4	Laundry	34,437	21,288		55,725		55,725		55,725			4
5	Heat and Other Utilities			138,373	138,373		138,373		138,373			5
6	Maintenance	60,632		76,997	137,629		137,629	36,221	173,850			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	522,257	267,720	222,521	1,012,498		1,012,498	33,592	1,046,090			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			36,000	36,000		36,000		36,000			9
10	Nursing and Medical Records	2,153,037	155,160	34,382	2,342,579		2,342,579		2,342,579			10
10a	Therapy			169,641	169,641		169,641		169,641			10a
11	Activities	76,149		14,010	90,159		90,159		90,159			11
12	Social Services	31,663		677	32,340		32,340		32,340			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	2,260,849	155,160	254,710	2,670,719		2,670,719		2,670,719			16
	<b>C. General Administration</b>											
17	Administrative			121,667	121,667		121,667		121,667			17
18	Directors Fees											18
19	Professional Services			73,175	73,175		73,175	2,461	75,636			19
20	Dues, Fees, Subscriptions & Promotions			22,175	22,175		22,175	(3,912)	18,263			20
21	Clerical & General Office Expenses	215,804	17,546	23,907	257,257		257,257	771	258,028			21
22	Employee Benefits & Payroll Taxes			472,977	472,977		472,977		472,977			22
23	Inservice Training & Education			1,003	1,003		1,003		1,003			23
24	Travel and Seminar			201	201		201		201			24
25	Other Admin. Staff Transportation			466	466		466		466			25
26	Insurance-Prop.Liab.Malpractice			128,074	128,074		128,074		128,074			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	215,804	17,546	843,645	1,076,995		1,076,995	(680)	1,076,315			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,998,910	440,426	1,320,876	4,760,212		4,760,212	32,912	4,793,124			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7**	8			
30	Depreciation			130,083	130,083		130,083	101,693	231,776			30
31	Amortization of Pre-Op. & Org.			600	600		600	600	600			31
32	Interest			81,694	81,694		81,694	361,272	442,966			32
33	Real Estate Taxes							99,996	99,996			33
34	Rent-Facility & Grounds			658,446	658,446		658,446	(658,446)				34
35	Rent-Equipment & Vehicles			33,706	33,706		33,706		33,706			35
36	Other (specify):*											36
37	TOTAL Ownership			904,529	904,529		904,529	(95,485)	809,044			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		208,244	3,112	211,356		211,356		211,356			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,772	83,772		83,772		83,772			42
43	Other (specify):* Nonallowable costs			61,899	61,899		61,899	(61,899)				43
44	TOTAL Special Cost Centers		208,244	148,783	357,027		357,027	(61,899)	295,128			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,998,910	648,670	2,374,188	6,021,768		6,021,768	(124,472)	5,897,296			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

\*\*See schedule of adjustments attached at end of cost report

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,629)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,922)	30		9
10	Interest and Other Investment Income	(975)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,006)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(3,120)	43		18
19	Entertainment				19
20	Contributions	(232)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(665)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(8,700)	43		24
25	Fund Raising, Advertising and Promotional	(48,841)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule <u>See attached 5A</u>	28,164			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (40,926)		\$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(83,546)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (83,546)		36
37	(sum of SUBTOTALS TOTAL ADJUSTMENTS (A) and (B) )	\$ (124,472)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.  
(See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	<u>Gift and Coffee Shops</u>		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

COMMUNITY NURSING & REHABILITATION CENTER, LLC  
FACILITY # 0044750  
DECEMBER 31, 2001

SCHEDULE 5A

Schedule VI. Part A - Adjustment Detail, Line 29

Non-allowable Expenses	Amount	Reference
Deferred Painting and Decorating	36,221	6
Chamber of Commerce Dues	(1,089)	20
Out-of-period Legal Fees	(1,339)	19
Offset miscellaneous income against expense	(2,806)	21
PAC Dues	(2,823)	20
Total Non-allowable Expenses	28,164	

SEE ACCOUNTANTS' COMPILATION REPORT

ID#0044750

Report Period Beginning:01/01/01

Ending:12/31/01

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Community Nursing &amp; Rehabilitation Center

# 0044750

Report Period Beginning:

01/01/01

Ending:

12/31/01

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,629)	0	0	0	0	0	0	0	0	0	0	(2,629)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(2,629)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(2,629)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(665)	4,465	0	0	0	0	0	0	0	0	0	3,800	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	3,577	0	0	0	0	0	0	0	0	0	3,577	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(665)</b>	<b>8,042</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>7,377</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(3,294)</b>	<b>8,042</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>4,748</b>	<b>29</b>



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mark and Chana Weldler	29.50%			Community Nursing &		
Steve and Bluma Jeremias	29.50%	Wheaton Care Center	Wheaton	Rehabilitation Realty,		
Malka Mermelstein	0.50%	Lakefront Healthcare Center, Inc.	Chicago	LLC	Naperville	Real Estate
Herman Mermelstein	0.50%					
Joseph Neumann	30.00%					
Hirsch Wolf	10.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	Professional Services	\$	Community Nursing & Rehabilitation Realty, LLC	100.00%	\$ 4,465	\$ 4,465	1
2	V	21	Clerical and Gen. Office Exp.		Community Nursing & Rehabilitation Realty, LLC	100.00%	3,577	3,577	2
3	V	30	Depreciation		Community Nursing & Rehabilitation Realty, LLC	100.00%	104,615	104,615	3
4	V	32	Amortization of Mortgage Costs		Community Nursing & Rehabilitation Realty, LLC	100.00%	10,740	10,740	4
5	V	32	Interest Expense		Community Nursing & Rehabilitation Realty, LLC	100.00%	351,507	351,507	5
6	V	33	Property Taxes		Community Nursing & Rehabilitation Realty, LLC	100.00%	99,996	99,996	6
7	V	34	Rent Expense	658,446	Community Nursing & Rehabilitation Realty, LLC	100.00%		(658,446)	7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 658,446			\$ 574,900	\$ * (83,546)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number      Community Nursing & Rehabilitation Cente      #      0044750      Report Period Beginning:      01/01/01      Ending:      12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1  Name	2  Title	3  Function	4  Ownership Interest	5  Compensation Received From Other Nursing Homes*	6  Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7  Compensation Included in Costs for this Reporting Period**		8  Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Steve Jeremias	Owner	Administrator	29.50%		40	100 %	A	\$ 60,833	L 17, C3	1
2	Mark Weldler	Owner	Administrative	29.50%	25,090	40	100 %	A	60,834	L 17, C3	2
3											3
4											4
5											5
6		A-Members' Payments									6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 121,667		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number    Community Nursing & Rehabilitation Center    #    0044750    Report Period Beginning:    01/01/01    Ending:    12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)    YES ☐    NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization \_\_\_\_\_  
Street Address \_\_\_\_\_  
City / State / Zip Code \_\_\_\_\_  
Phone Number (\_\_\_\_\_) \_\_\_\_\_  
Fax Number (\_\_\_\_\_) \_\_\_\_\_

	1 Schedule V Line Reference	2  Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4  Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6				N/A						6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	American National Bank		X	Mortgage	\$22,916.67	03/31/00	\$ 5,500,000	\$ 5,362,500	03/31/05	P+.0050	\$ 351,507	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	American National Bank		X	Working Capital	Interest Only	03/31/00	1,000,000	730,000	6/30/02	P+.0050	81,694	6	
7	Shareholder Loan	X		Working Capital	None	12/31/01	300,000	300,000	Demand	None		7	
8												8	
9	TOTAL Facility Related				\$22,916.67		\$ 6,800,000	\$ 6,392,500			\$ 433,201	9	
	B. Non-Facility Related*												
10								Amortization of Mortgage Costs			10,740	10	
11								Offset Interest Income			(975)	11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 9,765	14	
15	TOTALS (line 9+line14)						\$ 6,800,000	\$ 6,392,500			\$ 442,966	15	

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.

2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)2000

3. Under or (over) accrual (line 2 minus line 1).

4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)

5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C.  
(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)

6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.  
TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)

7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1996819979199810199995,68411200097,85812

2000 Real estate taxes were \$97,858 Use \$96,536 for 2001 accrual.

FOR OHF USE ONLY

13FROM R. E. TAX STATEMENT FOR 2000 \$13

14PLUS APPEAL COST FROM LINE 5 \$14

15LESS REFUND FROM LINE 6 \$15

16AMOUNT TO USE FOR RATE CALCULATION \$16

\$94,3981

\$97,8582

\$3,4603

\$96,5364

\$5

\$6

\$99,9967

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Community Nursing & Rehabilitation Cente COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0044750

CONTACT PERSON REGARDING THIS REPORT Mr. Mark Weldler

TELEPHONE 630 355-3300 FAX #: 630 355-1417

A. Summary of Real Estate Tax Cos

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2000

	(A)	(B)	(C)	(D)
	Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.	07-12-403-042	Nursing Home	\$ 97,858.36	\$ 97,858.36
2.			\$	\$
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 97,858.36	\$ 97,858.36

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:62,087

B. General Construction Type:ExteriorBrickFrameSteel

Number of Stories2

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☐ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred:3,000

2. Number of Years Over Which it is Being Amortized:5 Years

3. Current Period Amortization:600

4. Dates Incurred:04/01/00

Nature of Costs:Organization costs- legal fees

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2		3		4	
A. Land.		Use	Square Feet	Year Acquired	Cost		
1	Facility		164,335	2000	\$453,622	1	
2						2	
3	TOTALS		164,335		\$453,622	3	

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	153		2000	1986	\$ 4,184,589	\$	40	\$ 104,615	\$ 104,615	\$ 183,076	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Cable		2000		4,305	108	40	108		189	9
10	Elevator Door		2000		4,389	110	40	110		183	10
11	Parking Lot		2000		38,200	955	40	955		1,592	11
12	Landscaping		2000		8,736	218	40	218		345	12
13	Sign		2000		4,541	114	40	114		180	13
14	Architect Fees		2000		3,060	76	40	76		133	14
15	Door Lock		2000		2,248	56	40	56		89	15
16	Closets		2000		7,729	193	40	193		273	16
17	Cove Base		2000		4,459	111	40	111		139	17
18	Handrails and Kickplates		2000		15,146	379	40	379		474	18
19	Lighting		2000		65,796	1,645	40	1,645		2,056	19
20	Tile		2000		2,317	58	40	58		72	20
21	Flooring		2000		16,378	409	40	409		462	21
22	Exit Doors		2000		1,598	40	40	40		50	22
23	Window and Cubicle Treatments		2000		34,021	851	40	851		1,064	23
24	Lighting		2000		1,729	43	40	43		54	24
25	Carpeting		2000		27,139	678	40	678		848	25
26	Fire Panel		2000		4,500	113	40	113		141	26
27	Nurse's Station		2000		8,913	223	40	223		260	27
28	Door Handles		2000		1,644	41	40	41		48	28
29	Cubicle Track		2000		915	23	40	23		25	29
30	Motor		2000		13,276	332	40	332		498	30
31	Stove Hoods		2000		1,429	36	40	36		39	31
32	Cover Base- Residents' Rooms		2001		865	79	10	79		79	32
33	Ceramic Tiles		2001		10,930	1,002	10	1,002		1,002	33
34	Ceiling & Lighting		2001		9,063	831	10	831		831	34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Renovations - Therapy Room	2001	\$ 10,558	\$ 968	10	\$ 968	\$	\$ 968	37
38	Tile & Cove Base-Basement	2001	2,327	233	10	233		233	38
39	Shampoo Station	2001	5,431	498	10	498		498	39
40	Cove Base - Second Floor	2001	1,699	156	10	156		156	40
41	Wallpaper / Covebase/ Carpeting / Lighting	2001	1,403	129	10	129		129	41
42	ABS Pump	2001	11,908	1,092	10	1,092		1,092	42
43	Carpeting	2001	14,572	1,336	10	1,336		1,336	43
44	Flooring	2001	1,320	121	10	121		121	44
45	2nd floor Renovations	2001	38,875	2,916	10	2,916		2,916	45
46	Avery	2001	2,419	181	10	181		181	46
47	Kitchen - cooling air unit	2001	2,275	190	10	190		190	47
48	Wallcoverings	2001	12,289	1,229	10	1,229		1,229	48
49	Signage / Electric Ballast (Admissions Office)	2001	3,131	209	10	209		209	49
50	Room Curtain Divider	2001	2,003	134	10	134		134	50
51	Handrails & Bumper Guards	2001	17,855	1,190	10	1,190		1,190	51
52	Fire Alarm Transformer	2001	1,715	114	10	114		114	52
53	Temp Control on Air Handler	2001	9,519	635	10	635		635	53
54	Covebase / Landscaping / Lighting / Flooring	2001	2,642	176	10	176		176	54
55	Lighting - Corridors & Resident Rooms	2001	20,544	1,198	10	1,198		1,198	55
56	New Bearing & Shaft	2001	1,402	70	10	70		70	56
57	Dialysis Room Renovations	2001	23,351	195	10	195		195	57
58	Asphalt Sealcoating & Striping	2001	1,405	47	10	47		47	58
59	Kitchen Tile	2001	930	23	10	23		23	59
60	Septic tank pumps	2001	13,862	347	10	347		347	60
61	Carpeting	2001	5,729	334	10	334		334	61
62	Painting and Wallpaper	2001	20,440	2,044	10	2,044		2,044	62
63	Painting and Wallpaper	2001	11,875	891	10	891		891	63
64	Painting and Wallpaper	2001	4,500	263	10	263		263	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 4,723,894	\$ 25,643		\$ 130,258	\$ +	\$ 211,121	70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$4,723,894	\$25,643		\$130,258	\$104,615	\$211,121	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,723,894	\$25,643		\$130,258	\$104,615	\$211,121	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$4,723,894	\$25,643		\$130,258	\$104,615	\$211,121	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,723,894	\$25,643		\$130,258	\$104,615	\$211,121	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$4,723,894	\$25,643		\$130,258	\$104,615	\$211,121	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$4,723,894	\$25,643		\$130,258	\$104,615	\$211,121	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$953,081	\$99,749	\$99,749	\$	10 yrs	\$171,604	71
72	Current Year Purchases	36,966	1,118	1,118		10 yrs	1,118	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$990,047	\$100,867	\$100,867	\$		\$172,722	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	1988 Ford Econoline Bus	2000	\$3,255	\$651	\$651	\$	5	\$1,139	76
77										77
78										78
79										79
80	TOTALS			\$3,255	\$651	\$651	\$		\$1,139	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$6,170,818	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$127,161	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$231,776	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$104,615	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$384,982	85

\*\*

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?  
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.  
This amount was calculated by dividing the total amount to be amortized  
by the length of the lease
- 

9. Option to Buy:
- ☐ YES☐ NO
- Terms: \*

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?  
☐ YES☐ NO
16. Rental Amount for movable equipment: \$ 27,337Description: Computers \$ 14,976; Suction Machine \$ 8,158; Pulse Oximeter \$ 4,203  
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	1999 Acura	\$ 579.00	\$ 6,369	17
18					18
19					19
20					20
21	TOTAL		\$ 579.00	\$ 6,369	21

10. Effective dates of current rental agreement:  
Beginning  
Ending
11. Rent to be paid in future years under the current rental agreement:
- |     | Fiscal Year Ending | Annual Rent |
|-----|--------------------|-------------|
| 12. | /2002              | \$          |
| 13. | /2003              | \$          |
| 14. | /2004              | \$          |

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

It is the policy of this facility to only hire certified nurses aides  
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L 10a, C 3	hrs	\$	2,871	\$ 47,572	\$	2,871	\$ 47,572	1
2	Licensed Speech and Language Development Therapist	L 10a, C 3	hrs		1,457	20,925		1,457	20,925	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L 10a, C3	hrs		4,874	101,144		4,874	101,144	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L 39, C2	# of prescripts				208,244		208,244	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):   Laboratory	L39, C3				3,112			3,112	13
14	TOTAL			\$	9,202	\$ 172,753	\$ 208,244	9,202	\$ 380,997	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$224,196	\$227,288	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance8,700 )	1,500,439	1,500,439	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	70,804	70,804	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$1,795,439	\$1,798,531	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		453,622	13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	647,968	4,723,894	15
16	Equipment, at Historical Cost	993,302	993,302	16
17	Accumulated Depreciation (book methods)	(205,753)	(384,982)	17
18	Deferred Charges		54,332	18
19	Organization & Pre-Operating Costs	3,000	3,000	19
	Accumulated Amortization - Organization & Pre-Operating Costs	(1,050)	(1,050)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify)Mortgage costs		34,907	22
23	Other(specify): Deposits	13,495	13,495	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$1,450,962	\$5,890,520	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$3,246,401	\$7,689,051	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$504,677	\$504,677	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,030,000	1,305,000	29
30	Accrued Salaries Payable	35,613	35,613	30
31	Accrued Taxes Payable (excluding real estate taxes)	15,270	15,270	31
32	Accrued Real Estate Taxes(Sch.IX-B)		96,536	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See attached Schedule 17A	1,331,646	193,451	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$2,917,206	\$2,150,547	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		5,087,500	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$5,087,500	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$2,917,206	\$7,238,047	46
47	TOTAL EQUITY(page 18, line 24)	\$329,195	\$451,004	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$3,246,401	\$7,689,051	48

COMMUNITY NURSING & REHABILITATION CENTER, LLC  
FACILITY # 0044750  
12/31/2001

**SCHEDULE 17A**

Schedule XV. Balance Sheet Part C. Line 36

	<u>Operating</u>	<u>After Consolidation</u>
Wage Garnishment	792	792
401K Liability	8,331	8,331
Accrued Assessment Fee	777	777
Due to Credit Union	655	655
Due To State	109,148	109,148
Due To Patient Trust Fund	72,899	72,899
Refund - Due to Private	3,290	3,290
Due/Third Party Payor	(2,441)	(2,441)
Due To/From CNRR	<u>1,138,195</u>	<u>0</u>
Total	<u><u>1,331,646</u></u>	<u><u>193,451</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 562,306	1
2	Restatements (describe):		2
3	Rounding	1	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 562,307	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(233,112)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (233,112)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 329,195	24 *

Operating entity only

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Community Nursing & Rehabilitation Center # 0044750 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required

classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,590,128	1
2	Discounts and Allowances for all Levels	(764,935)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 4,825,193	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	368,853	6
7	Oxygen	65,201	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 434,054	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,705	12
13	Barber and Beauty Care	1,081	13
14	Non-Patient Meals	355	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	378,452	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	141,761	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 523,354	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	975	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 975	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income (Offset against expense)	5,080	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 5,080	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,788,656	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,012,498	31
32	Health Care	2,670,719	32
33	General Administration	1,076,995	33
	B. Capital Expense		
34	Ownership	904,529	34
	C. Ancillary Expense		
35	Special Cost Centers	273,255	35
36	Provider Participation Fee	83,772	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 6,021,768	40
41	Income before Income Taxes (line 30 minus line 40)**	(233,112)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (233,112)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. This entity is a cash basis tax payer

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\* Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)  
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,060	2,200	\$ 66,434	\$ 30.20	1
2	Assistant Director of Nursing	1,502	1,534	41,130	26.81	2
3	Registered Nurses	23,005	24,207	486,829	20.11	3
4	Licensed Practical Nurses	16,327	17,203	332,163	19.31	4
5	Nurse Aides & Orderlies	75,654	79,122	1,057,172	13.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,054	2,274	29,595	13.01	8
9	Activity Director	2,001	2,160	28,496	13.19	9
10	Activity Assistants	5,762	5,912	47,653	8.06	10
11	Social Service Workers	2,120	2,114	31,663	14.98	11
12	Dietician	4,143	4,423	51,703	11.69	12
13	Food Service Supervisor	2,024	2,160	38,668	17.90	13
14	Head Cook	9,071	9,793	97,313	9.94	14
15	Cook Helpers/Assistants	11,996	12,743	98,781	7.75	15
16	Dishwashers					16
17	Maintenance Workers	3,898	4,300	60,632	14.10	17
18	Housekeepers	17,214	18,431	140,723	7.64	18
19	Laundry	4,477	4,741	34,437	7.26	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	6,979	7,446	172,288	23.14	22
23	Office Manager					23
24	Clerical	3,836	4,006	43,516	10.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,114	2,312	24,626	10.65	31
32	Other Health CaSee Sched 20A	7,235	7,751	115,088	14.85	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	203,472	214,832	\$ 2,998,910 *	\$ 13.96	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	2,717	\$ 7,151	L 1, C 3	35
36	Medical Director	Monthly	36,000	L 9, C 3	36
37	Medical Records Consultant	Monthly	740	L 10, C 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	Monthly	677	L 12, C 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,717	\$ 44,568		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	699	\$ 30,042	L 10, C 3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	699	\$ 30,042		53

SEE ACCOUNTANTS' COMPILATION REPORT

COMMUNITY NURSING & REHABILITATION CENTER, LLC  
FACILITY # 0044750  
12/31/2001

SCHEDULE 20 A

XVIII. A. STAFFING AND SALARY COSTS, Line 32

	# of Hrs. Worked	# of Hrs. Paid	Reporting Salaries	Average Wage
Staffing Coordinator	1,317	1,353	29,344	\$ 21.69
Central Supply Clerk	2,095	2,326	31,986	\$ 13.75
Care Plan Coordinator	3,823	4,072	53,758	\$ 13.20
	7,235	7,751	115,088	

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description		Amount	Description	Amount
			\$	Workers' Compensation Insurance	\$	75,444	IDPH License Fee	\$ 400
				Unemployment Compensation Insurance		49,953	Advertising: Employee Recruitment	11,618
				FICA Taxes		224,074	Health Care Worker Background Check	850
				Employee Health Insurance		105,899	(Indicate # of checks performed 121 )	
				Employee Meals			Illinois Council on Long Term Care Dues	3,495
				Illinois Municipal Retirement Fund (IMRF)*			Miscellaneous Licenses	1,050
				401 K Expense		9,125	Miscellaneous Subscriptions	236
				Other Employee Benefits		8,482	Miscellaneous Dues	614
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)								
B. Administrative - Other							Less: Public Relations Expense	( )
Description			Amount				Non-allowable advertising	( )
Steve Jeremias- Administrator			\$ 60,833				Yellow page advertising	( )
Mark Weldler			60,834					
				TOTAL (agree to Schedule V, line 22, col.8)	\$	472,977	TOTAL (agree to Sch. V, line 20, col. 8)	\$ 18,263
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
C. Professional Services				Description	Line #	Amount	Description	Amount
Vendor/Payee	Type		Amount				Out-of-State Travel	\$
Health Data Systems, Inc.	Computer Services	\$	17,805					
Power Software Development	Computer Services		2,637					
Paychex	Computer Services		6,255				In-State Travel	121
Jacobs Health Care	Computer Services		5,244					
RCN	Computer Services		310					
XO - DSL	Computer Services		25	N/A				
American Express Tax & Bus. Serv.	Accounting		23,012				Seminar Expense	80
Sachnoff & Weaver, LTD.	Legal		9,645					
Accu-Med Services	Computer Services		900					
Personnel Planners	U/C Consulting		2,036					
Meyer Magence	Legal		1,181				Entertainment Expense	( )
Metropolitan Life	401k Consultant		4,125				(agree to Sch. V, line 24, col. 8)	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)				TOTAL		\$	TOTAL	\$ 201

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

\*\*See instructions.

COMMUNITY NURSING & REHABILITATION CENTER, LLC  
FACILITY # 0044750  
DECEMBER 31, 2001

SCHEDULE 21A

Schedule XIX. Part C - Professional Services

Professional fees (agrees to Schedule V, Line 19, column 3)		73,175
Disallow out-of-period legal	(1,339)	
Non-allowable legal fees	<u>(665)</u>	
subtotal		(2,004)
Legal fees from Community Nursing & Rehabilitation Realty, LLC	4,113	
Other professional fees	<u>352</u>	
		4,465
Professional fees (agrees to Schedule V, Line 19, column 8)		<u><u>75,636</u></u>

SEE ACCOUNTANTS' COMPILATION REPORT

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	Painting & Decorating	09/2000	\$ 108,663	3	\$	\$	\$ 18,110	\$ 36,221	\$ 36,222	\$ 18,110	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 108,663		\$	\$	\$ 18,110	\$ 36,221	\$ 36,222	\$ 18,110	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		Community Nursing & Rehabilitation Center		STATE OF ILLINOIS	#	0044750	Report Period Beginning:	01/01/01	Ending:	12/31/01
XX. GENERAL INFORMATION:										
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			<u>No</u>						
(2)	Are there any dues to nursing home associations included on the cost report?			<u>Yes</u>						
	If YES, give association name and amount.			<u>Illinois Council for Long- Term Care \$3,495</u>						
(3)	Did the nursing home make political contributions or payments to a political action organization?			<u>Yes</u>						
	If YES, have these costs been properly adjusted out of the cost report?			<u>Yes</u>						
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?			<u>No</u>						
	If YES, what is the capacity?			<u>N/A</u>						
(5)	Have you properly capitalized all major repairs and equipment purchases?			<u>Yes</u>						
	What was the average life used for new equipment added during this period?			<u>10 years</u>						
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ <u>4,262</u> Line <u>10</u>						
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?			<u>Yes</u>						
	If NO, attach a complete explanation.									
(8)	Are you presently operating under a sale and leaseback arrangement?			<u>No</u>						
	If YES, give effective date of lease.			<u>N/A</u>						
(9)	Are you presently operating under a sublease agreement?			YES <u>X</u> NO						
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES NO <u>X</u>						
	If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.			<u>N/A</u>						
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.			\$ <u>83,772</u>						
	This amount is to be recorded on line 42 of Schedule V.									
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?			<u>No</u>						
	If YES, attach an explanation of the allocation.									
SEE ACCOUNTANTS' COMPILATION REPORT										
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			<u>Yes</u>						
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?			<u>No</u>						
	For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.									
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.			\$ <u>0</u>						
	Has any meal income been offset against related costs?			<u>Yes</u>						
	Indicate the amount.			\$ <u>2,629</u>						
(16)	Travel and Transportation									
	a. Are there costs included for out-of-state travel?			<u>No</u>						
	If YES, attach a complete explanation.									
	b. Do you have a separate contract with the Department to provide medical transportation for residents?			<u>No</u>						
	If YES, please indicate the amount of income earned from such a program during this reporting period.			\$ <u>N/A</u>						
	c. What percent of all travel expense relates to transportation of nurses and patients?			<u>10%</u>						
	d. Have vehicle usage logs been maintained?			<u>Adequate logs are maintained</u>						
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			<u>Yes</u>						
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			<u>N/A</u>						
	g. Does the facility transport residents to and from day training?			<u>No</u>						
	Indicate the amount of income earned from providing such transportation during this reporting period.			\$ <u>N/A</u>						
(17)	Has an audit been performed by an independent certified public accounting firm?			<u>No</u>						
	Firm Name:			<u>N/A</u>						
	The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?			<u>N/A</u>						
	If no, please explain.			<u>N/A</u>						
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			<u>Yes</u>						
(19)	If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?			<u>Yes</u>						
	Attach invoices and a summary of services for all architect and appraisal fees.									

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	286,465	47,144	7,151	340,760	0	340,760	0	340,760
2. Food P	0	174,580	0	174,580	0	174,580	-2,629	171,951
3. Housek	140,723	24,708	0	165,431	0	165,431	0	165,431
4. Laundry	34,437	21,288	0	55,725	0	55,725	0	55,725
5. Heat ar	0	0	138,373	138,373	0	138,373	0	138,373
6. Mainte	60,632	0	76,997	137,629	0	137,629	36,221	173,850
7. Other (	0	0	0	0	0	0	0	0
8. Total G	522,257	267,720	222,521	1,012,498	0	1,012,498	33,592	1,046,090
9. Medical	0	0	36,000	36,000	0	36,000	0	36,000
10. Nursin	2,153,037	155,160	34,382	2,342,579	0	2,342,579	0	2,342,579
10a. Ther	0	0	169,641	169,641	0	169,641	0	169,641
11. Activi	76,149	0	14,010	90,159	0	90,159	0	90,159
12. Social	31,663	0	677	32,340	0	32,340	0	32,340
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total I	2,260,849	155,160	254,710	2,670,719	0	2,670,719	0	2,670,719
17. Admin	0	0	121,667	121,667	0	121,667	0	121,667
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	73,175	73,175	0	73,175	2,461	75,636
20. Fees,	0	0	22,175	22,175	0	22,175	-3,912	18,263
21. Cleric	215,804	17,546	23,907	257,257	0	257,257	771	258,028
22. Emplo	0	0	472,977	472,977	0	472,977	0	472,977
23. Inserv	0	0	1,003	1,003	0	1,003	0	1,003
24. Travel	0	0	201	201	0	201	0	201
25. Other	0	0	466	466	0	466	0	466
26. Insura	0	0	128,074	128,074	0	128,074	0	128,074
27. Other	0	0	0	0	0	0	0	0
28. Total C	215,804	17,546	843,645	1,076,995	0	1,076,995	-680	1,076,315
29. Total C	2,998,910	440,426	1,320,876	4,760,212	0	4,760,212	32,912	4,793,124
30. Depre	0	0	130,083	130,083	0	130,083	101,693	231,776
31. Amort	0	0	600	600	0	600	0	600
32. Intere	0	0	81,694	81,694	0	81,694	361,272	442,966
33. Real E	0	0	0	0	0	0	99,996	99,996
34. Rent -	0	0	658,446	658,446	0	658,446	-658,446	0
35. Rent -	0	0	33,706	33,706	0	33,706	0	33,706
36. Other	0	0	0	0	0	0	0	0
37. Total C	0	0	904,529	904,529	0	904,529	-95,485	809,044
38. Medic	0	0	0	0	0	0	0	0
39. Ancill	0	208,244	3,112	211,356	0	211,356	0	211,356
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	83,772	83,772	0	83,772	0	83,772
43. Other	0	0	61,899	61,899	0	61,899	-61,899	0
44. Total S	0	208,244	148,783	357,027	0	357,027	-61,899	295,128
45. Grand	2,998,910	648,670	2,374,188	6,021,768	0	6,021,768	-124,472	5,897,296

	After	
	Operating	Consolidation
General Service Cost Center		
1. Cash on	224,196	227,288
2. Cash - F	0	0
3. Account	1,500,439	1,500,439
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	70,804	70,804
7. Other Pi	0	0
8. Account	0	0
9. Other (s	0	0
10. Total c	1,795,439	1,798,531
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	0	453,622
14. Buildin	0	0
15. Leaseh	647,968	4,723,894
16. Equipn	993,302	993,302
17. Accum	-205,753	-384,982
18. Deferre	0	54,332
19. Organi	3,000	3,000
20. Accum	-1,050	-1,050
21. Restric	0	0
22. Other l	0	34,907
23. other (s	13,495	13,495
24. Total L	1,450,962	5,890,520
25. Total A	3,246,401	7,689,051
CURRENT LIABILITIES		
26. Accour	504,677	504,677
27. Officer'	0	0
28. Accour	0	0
29. Short-T	0	275,000
30. Accrue	35,613	35,613
31. Accrue	15,270	15,270
32. Accrue	0	96,536
33. Accrue	0	0
34. Deferre	0	0
35. Federa	0	0
36. Other (	1,331,646	193,451
37. Other (	0	0
38. Total C	1,887,206	1,120,547
LONG TERM LIABILITES		
39. Long-Ti	1,030,000	6,117,500
40. Mortga	0	0
41. Bonds l	0	0
42. Deferre	0	0
43. Other L	0	0
44. Other L	0	0
45. Total L	1,030,000	6,117,500
46. Total Li	2,917,206	7,238,047
47. Total Ei	329,195	451,004
48. Total Li	3,246,401	7,689,051

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	5,590,128
2. Discounts and Allowances for all Levels	-764,935
Subtotal - Inpatient Care	4,825,193
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	368,853
7. Oxygen	65,201
Subtotal - Ancillary Revenue	434,054
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements -	
12. Gift and Coffee Shop	1,705
13. Barber and Beauty Care	1,081
14. Non-Patient Meals	355
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	378,452
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	141,761
22. Laundry	0
Subtotal - Other Operating Revenue	523,354
24. Contributions	0
25. Interest and Other Investments Income	975
Subtotal - Non-Operating Revenue	975
27. Other Revenue (specify):	5,080
28. Other Revenue (specify):	0
Subtotal - Other Revenue	5,080
30. Total Revenue	5,788,656
31. General Services	1,012,498
32. Health Care	2,670,719
33. General Administration	1,076,995
34. Ownership	904,529
35. Special Cost Centers	273,255
35. Provider Participation Fee	83,772
37. Other	0
40. Total Expenses	6,021,768
41. Income Before Income Taxes	-233,112
42. Income Taxes	0
43. Net Income or Loss for the Year	-233,112

RECONCILIATION REPORT

Community Nursing & R

02:24 PM

11/07/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-124,472	equal to	-124,472	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	442,966	equal to	442,966	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	99,996	equal to	99,996	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	600	equal to	600	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	231,776	equal to	231,776	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	33,706	equal to	33,706	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	169,641	equal to	169,641	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies	208,244	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,012,498	equal to	1,012,498	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,870,719	equal to	2,870,719	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,076,995	equal to	1,076,995	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	904,529	equal to	904,529	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	273,255	equal to	273,255	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	83,772	equal to	83,772	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,008,354	equal to	2,153,037	-144,683	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	76,149	equal to	76,149	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	31,663	equal to	31,663	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	286,465	equal to	286,465	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	60,632	equal to	60,632	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	140,723	equal to	140,723	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	34,437	equal to	34,437	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	172,288	equal to		0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	43,516	equal to	215,804	-172,288	FAILED	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	2,998,910	equal to	2,998,910	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	7,151	< or = to	7,151	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	36,000	< or = to	36,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	30,782	< or = to	34,382	-3,600	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	14,010	-14,010	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	677	< or = to	677	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.		equal to		0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	121,667	equal to	121,667	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	73,175	equal to	73,175	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	472,977	equal to	472,977	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	18,263	equal to	18,263	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	201	equal to	201	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	83,772	equal to	83,772	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	4,672	equal to	5,824	-1,152	FAILED	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-83,546	equal to	-83,546	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	6,392,500	equal to	6,392,500	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	96,536	equal to	96,536	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	453,622	equal to	453,622	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	4,723,894	equal to	4,723,894	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	993,302	equal to	993,302	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	384,982	equal to	384,982	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	329,195	equal to	329,195	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-233,112	equal to	-233,112	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	54,332	equal to	54,332	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,246,401	equal to	3,246,401	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1